

FIG. 2

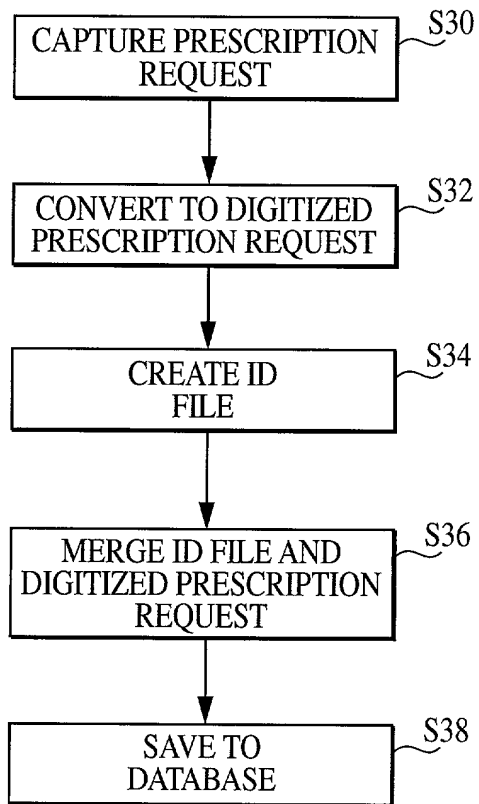


FIG. 3

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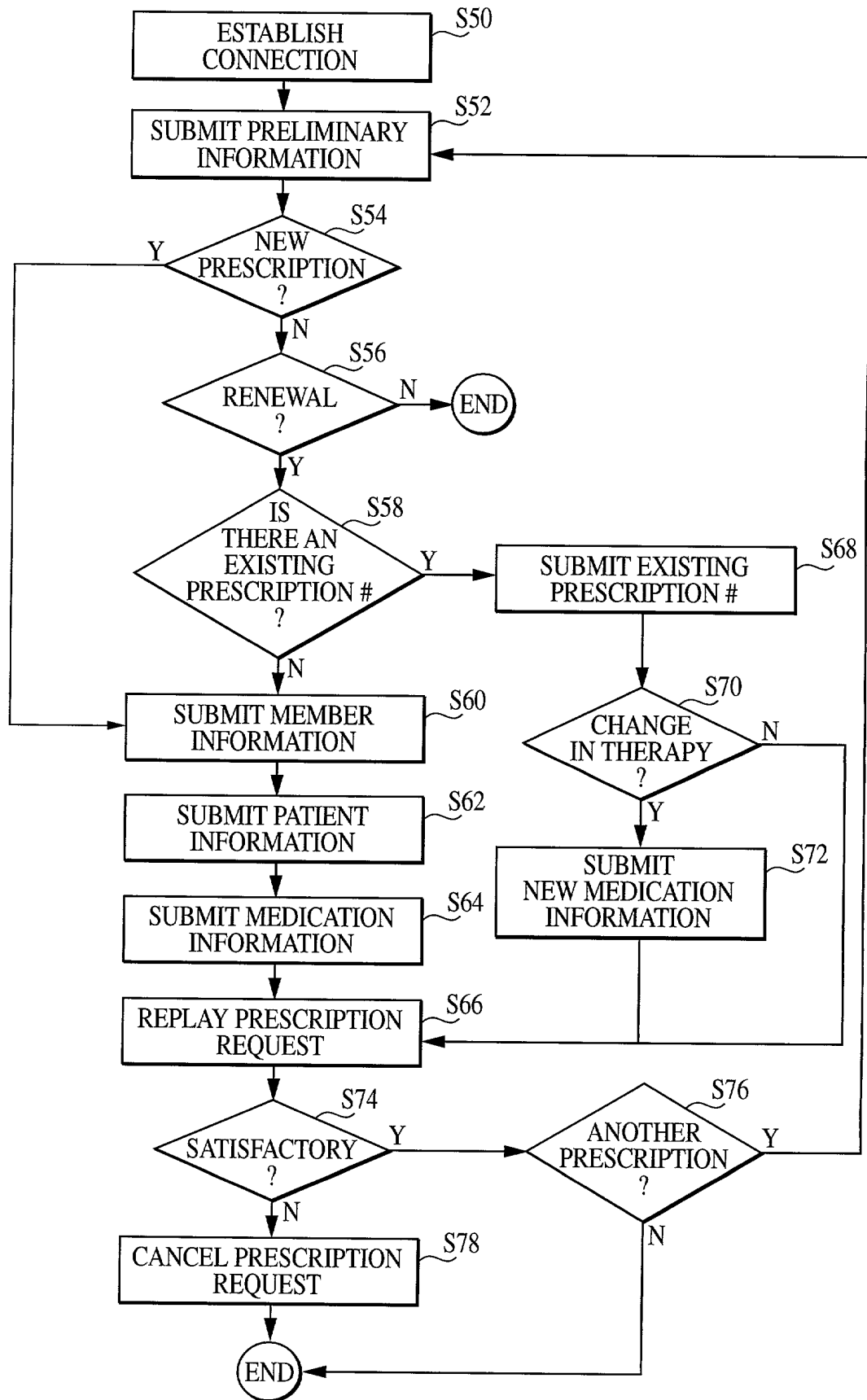


FIG. 4

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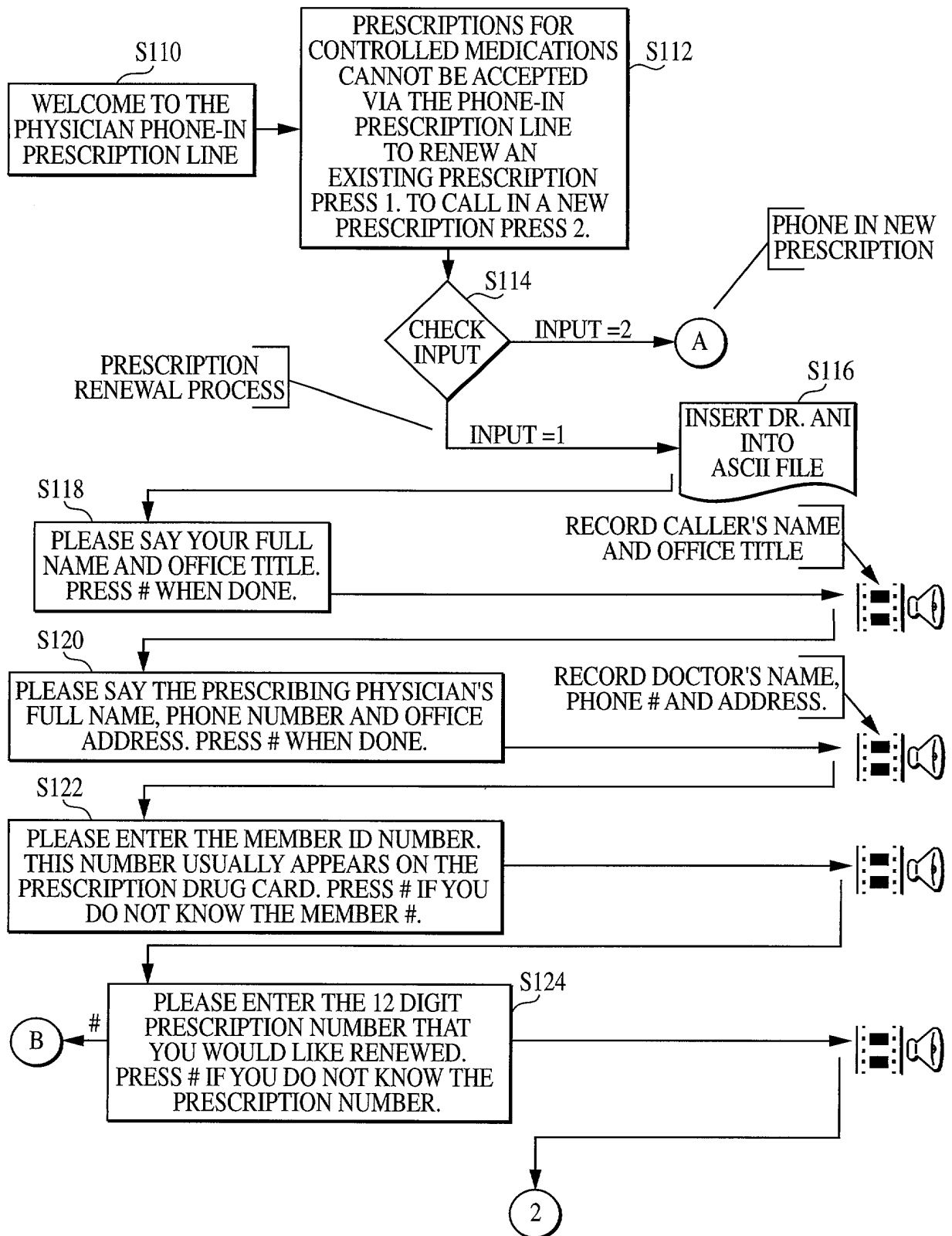


FIG. 5A

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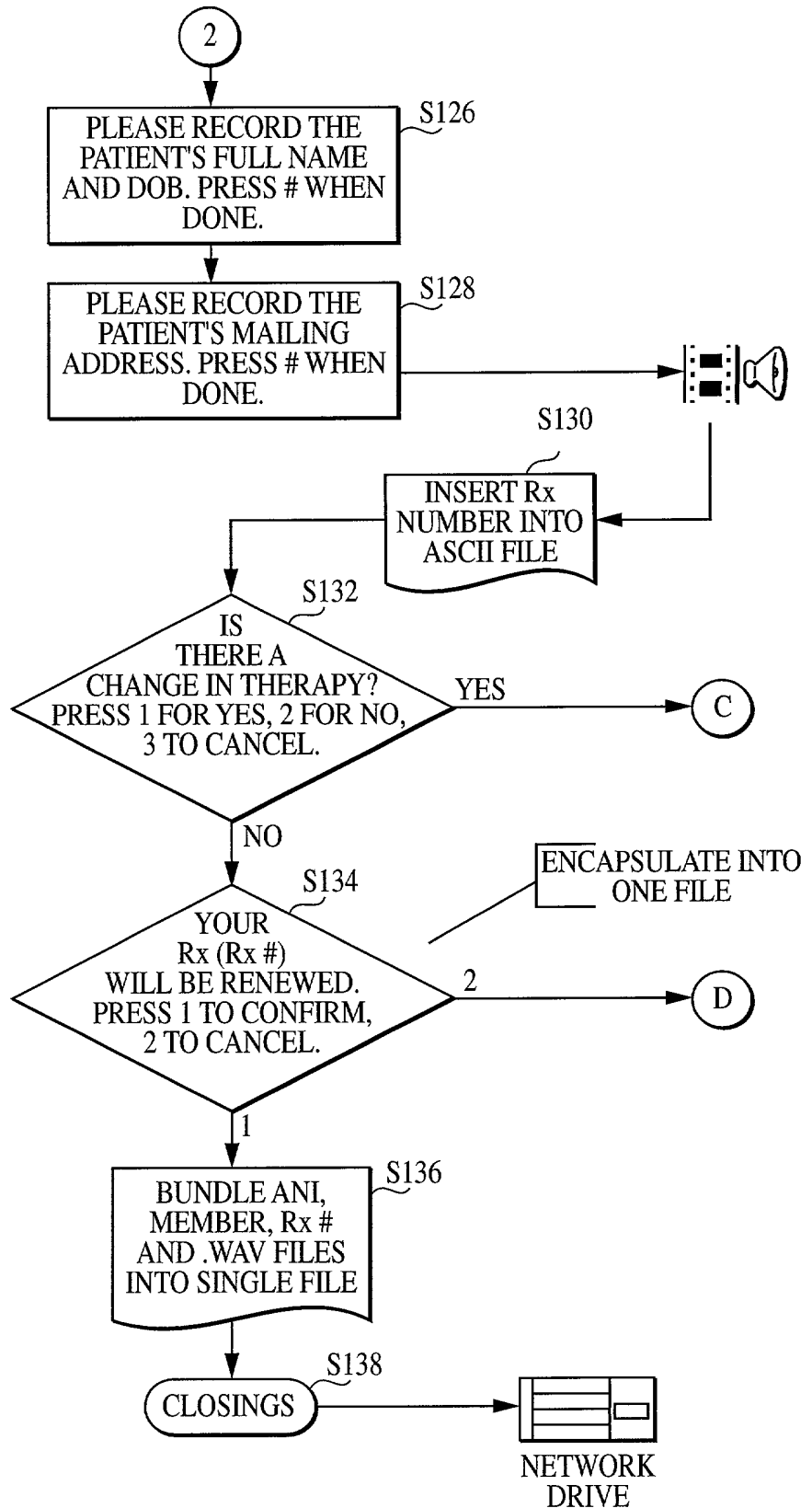


FIG. 5B

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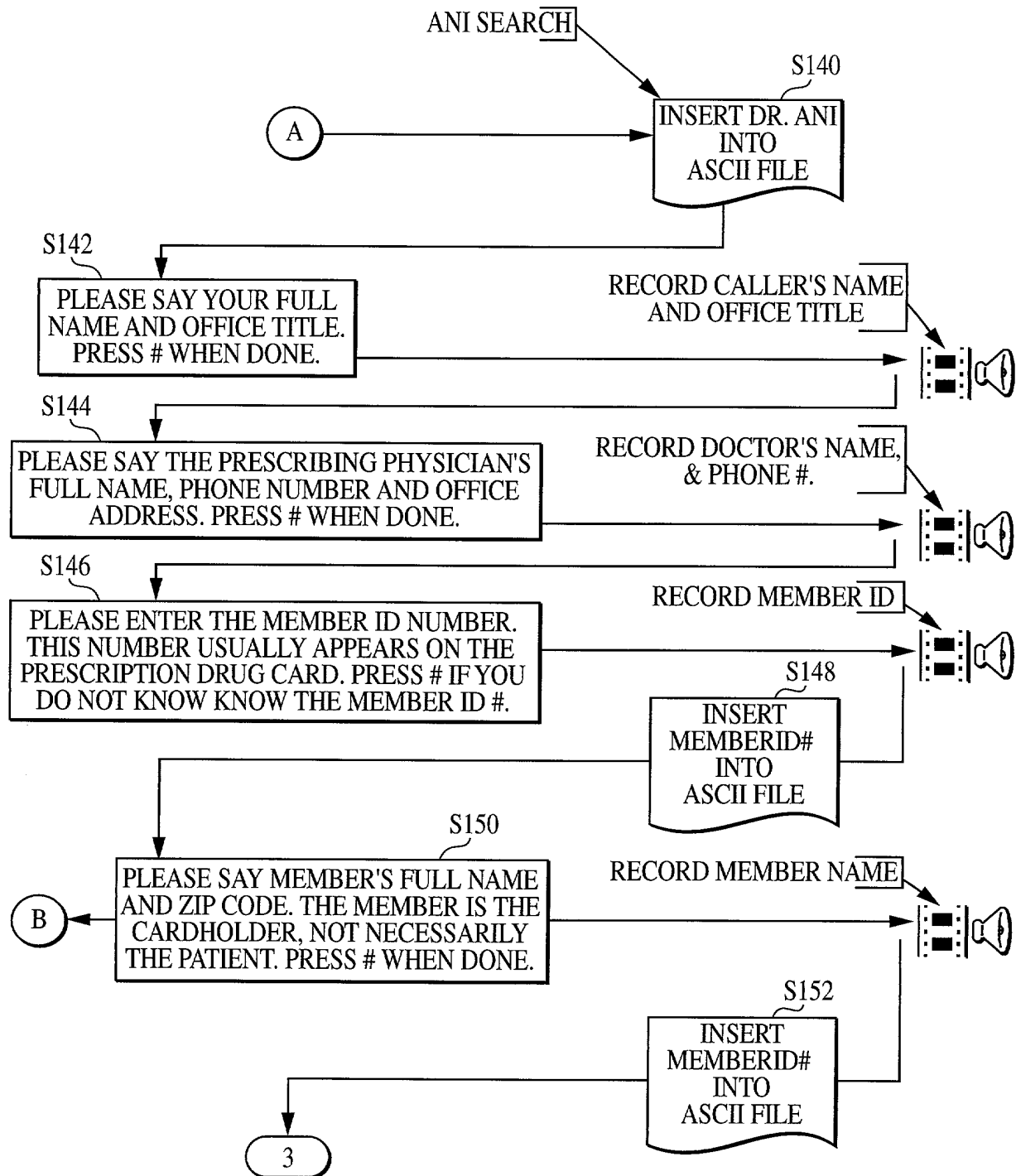
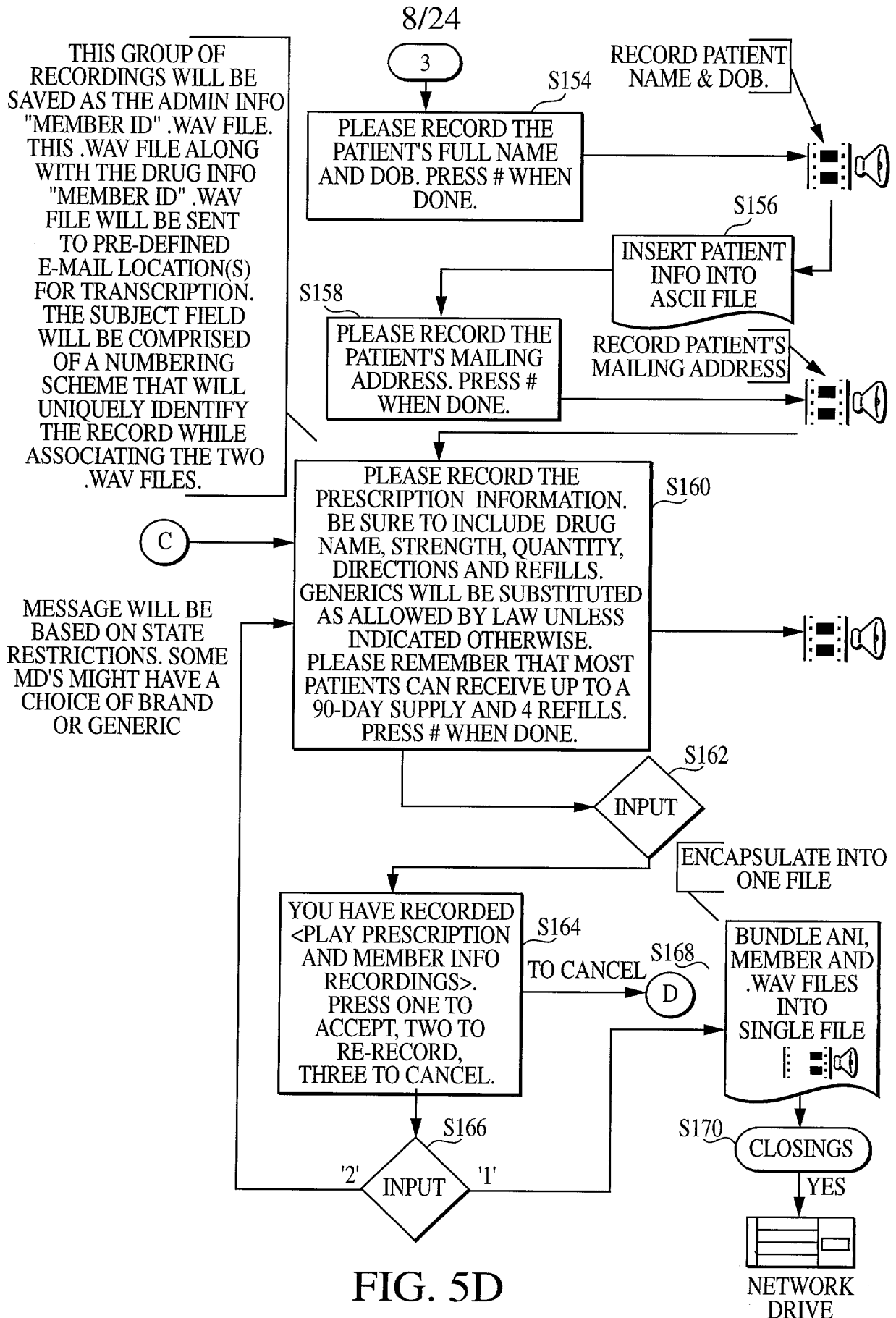


FIG. 5C



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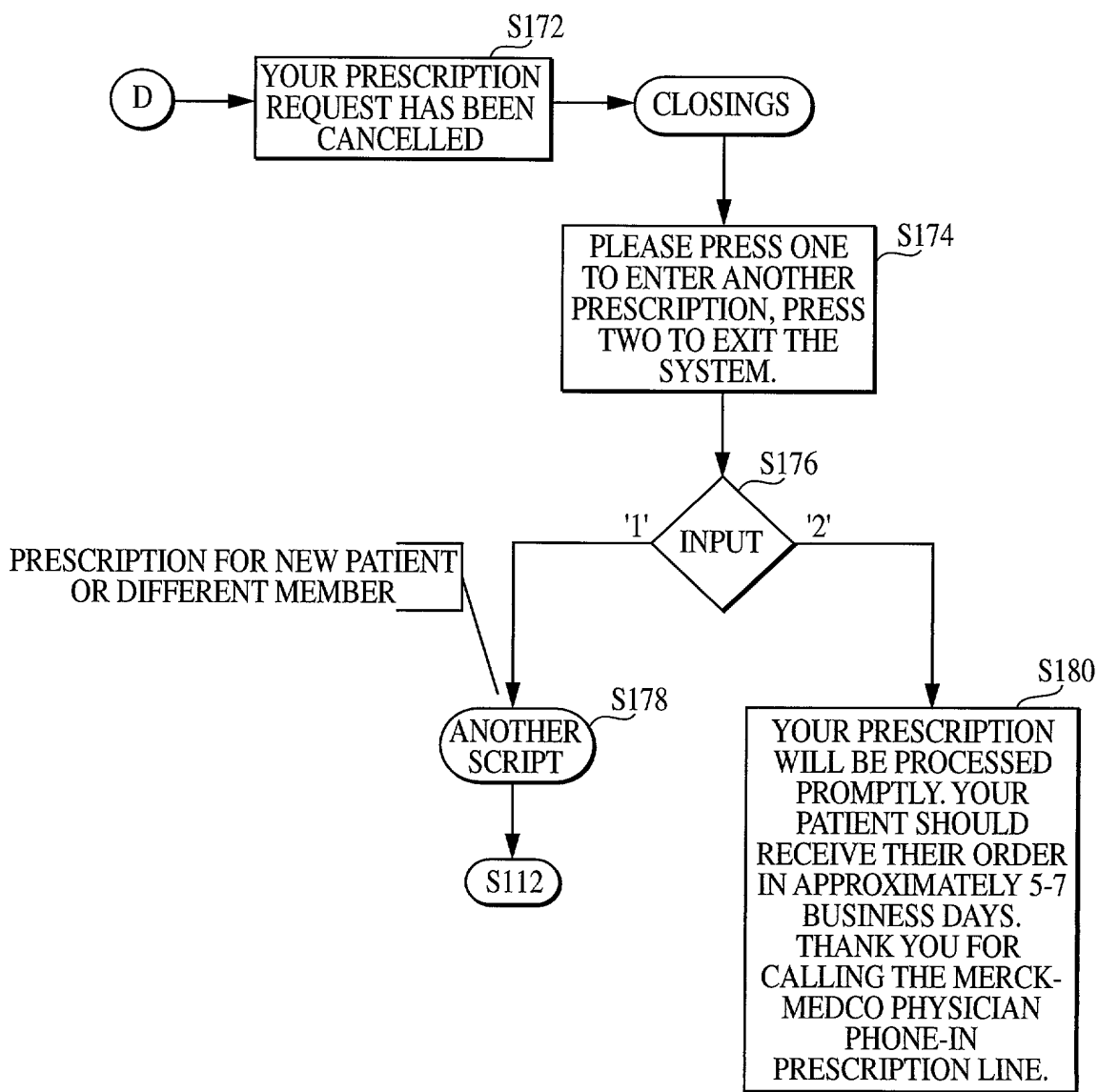
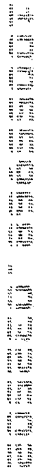


FIG. 5E

[illegible]

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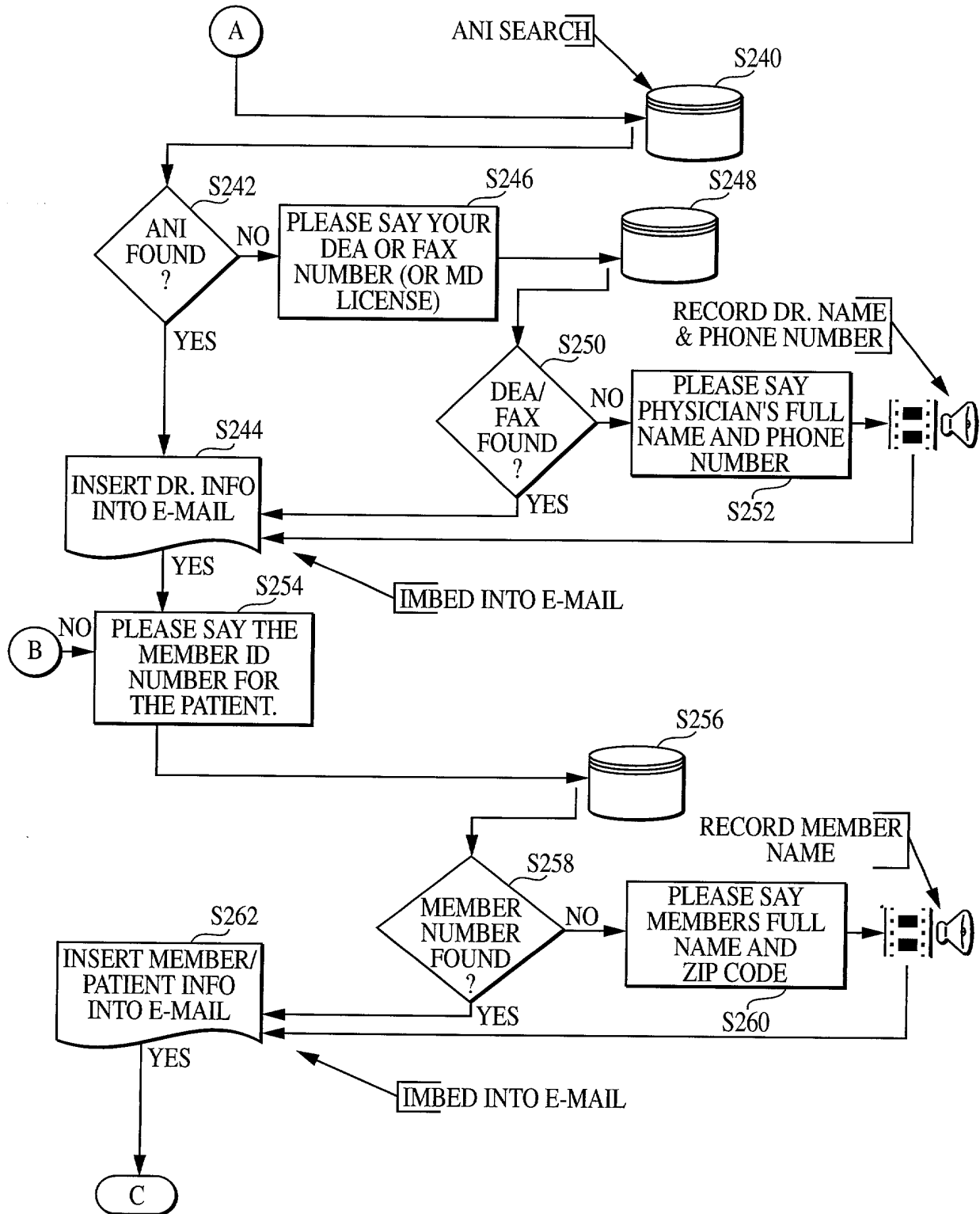


FIG. 6B

THIS GROUP OF RECORDINGS WILL BE SAVED AS THE ADMIN INFO "MEMBER ID" .WAV FILE. THIS .WAV FILE ALONG WITH THE DRUG INFO "MEMBER ID" .WAV FILE WILL BE SENT TO PRE-DEFINED E-MAIL LOCATION(S) FOR TRANSCRIPTION. THE SUBJECT FIELD WILL BE COMPRISED OF A NUMBERING SCHEME THAT WILL UNIQUELY IDENTIFY THE RECORD WHILE ASSOCIATING THE TWO .WAV FILES.

MESSAGE WILL BE BASED ON MD STATE RESTRICTIONS. SOME MD'S MIGHT HAVE A CHOICE OF BRAND OR GENERIC.

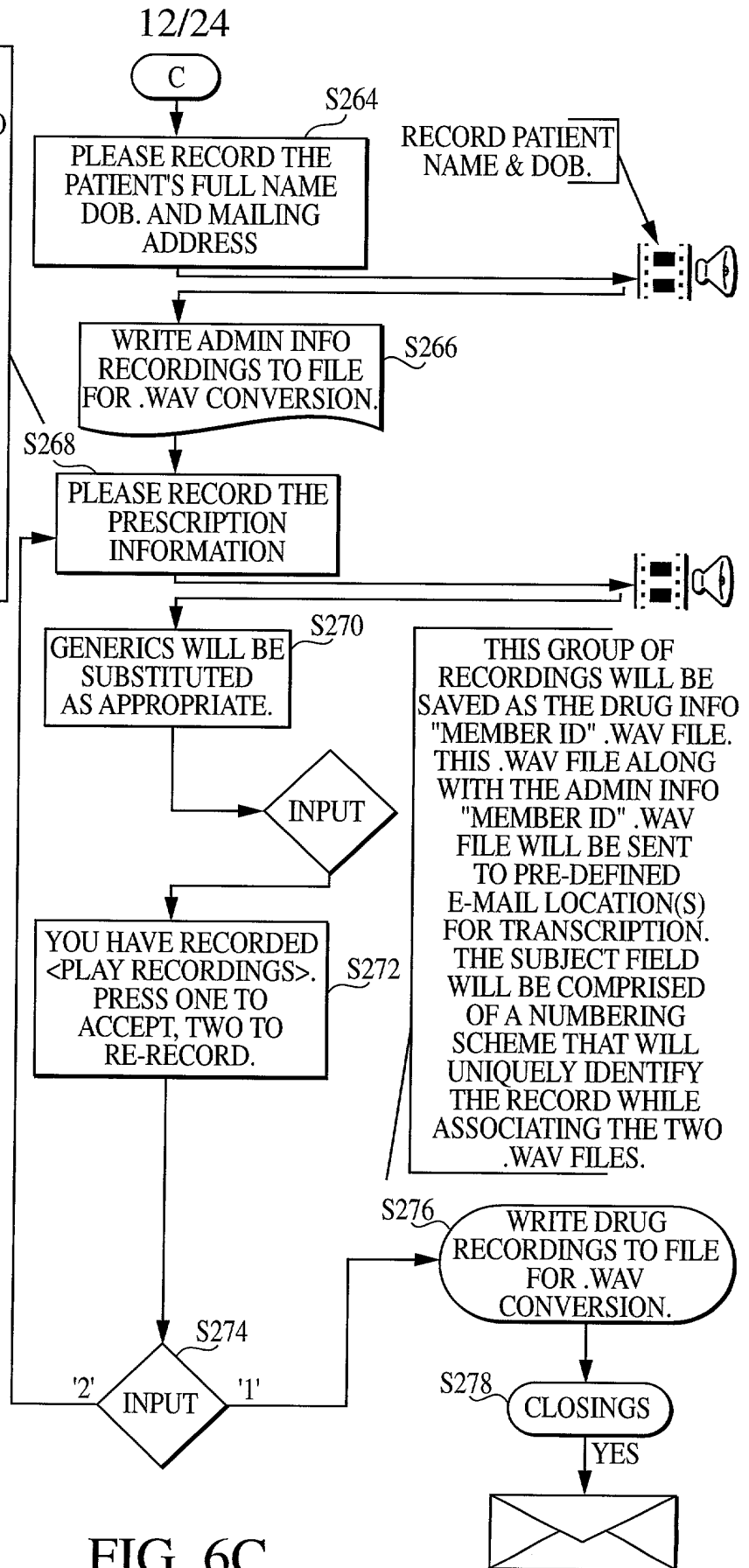


FIG. 6C

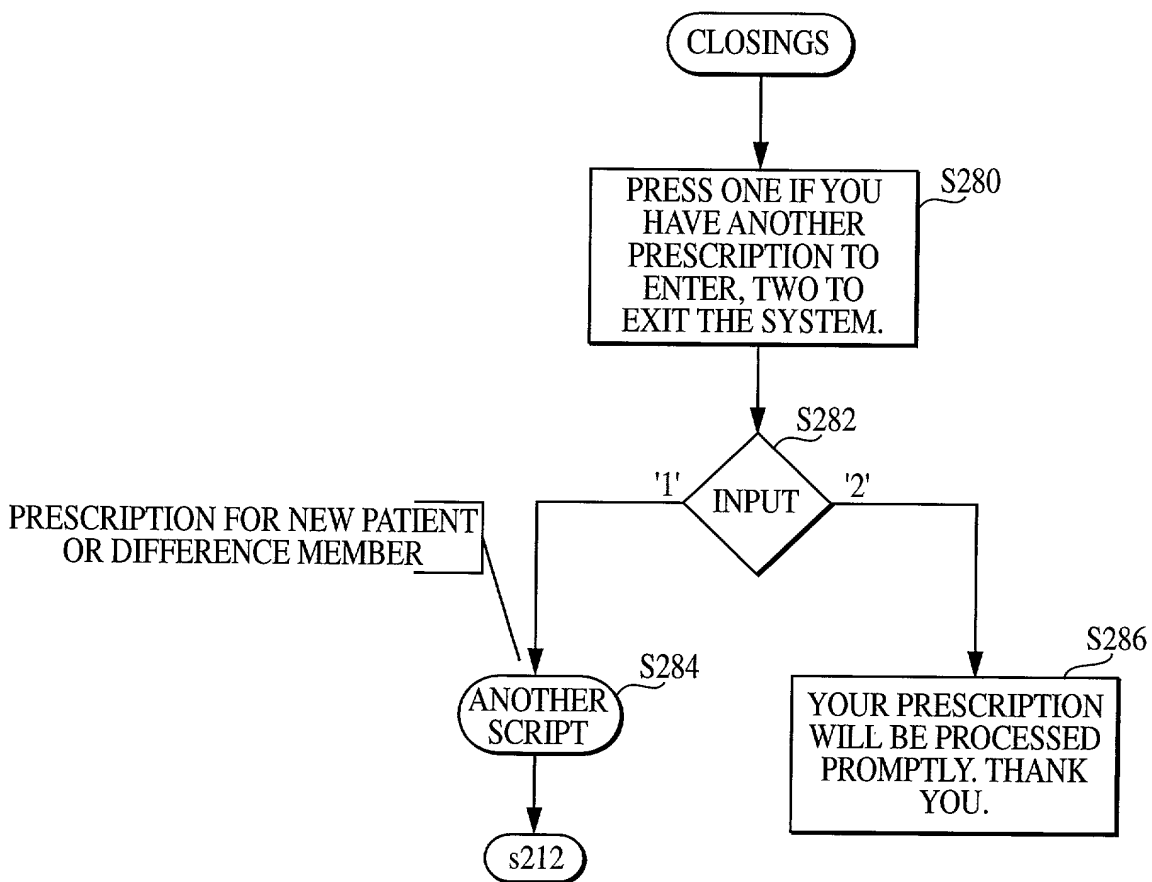


FIG. 6D

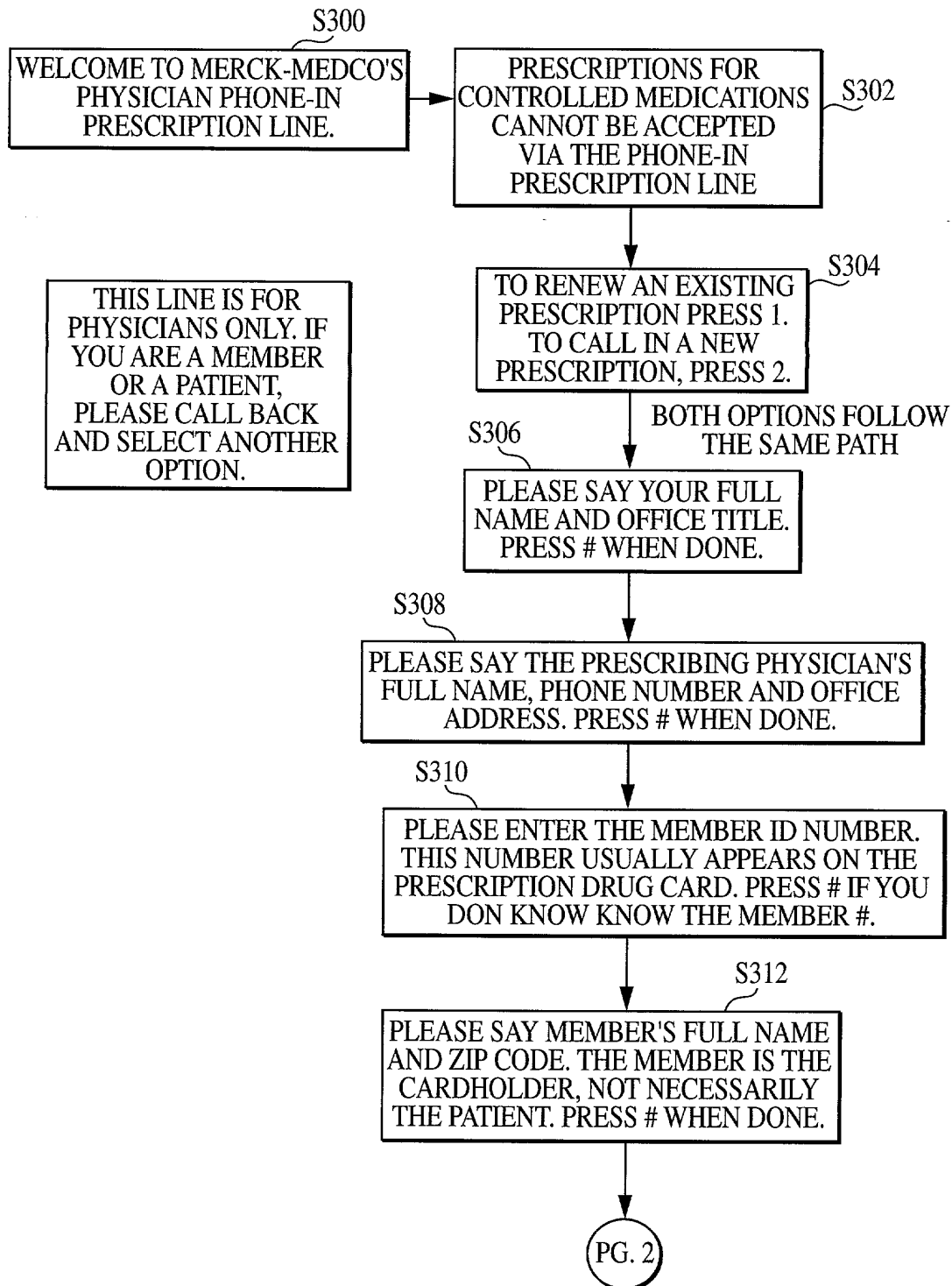


FIG. 7A

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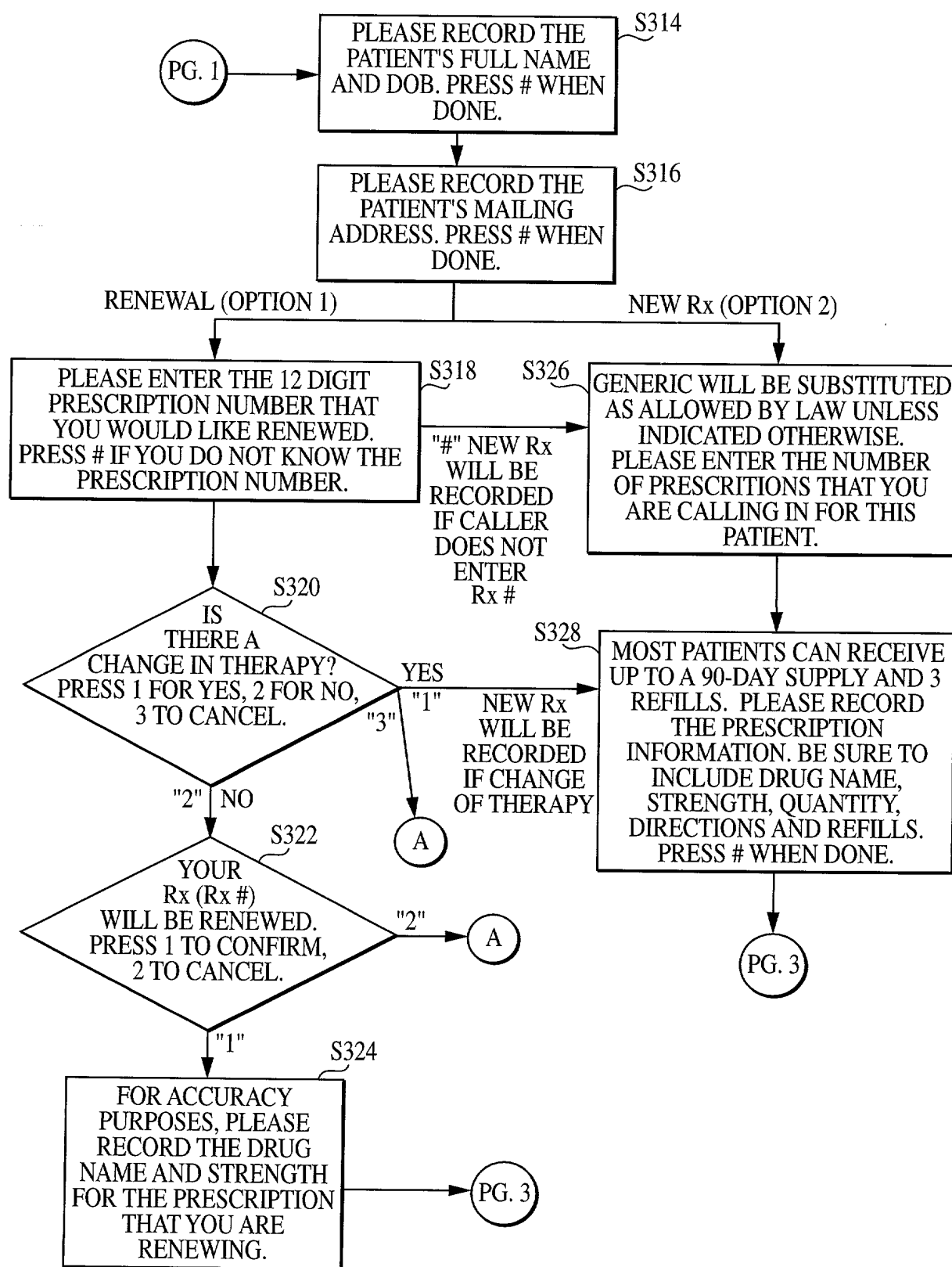


FIG. 7B

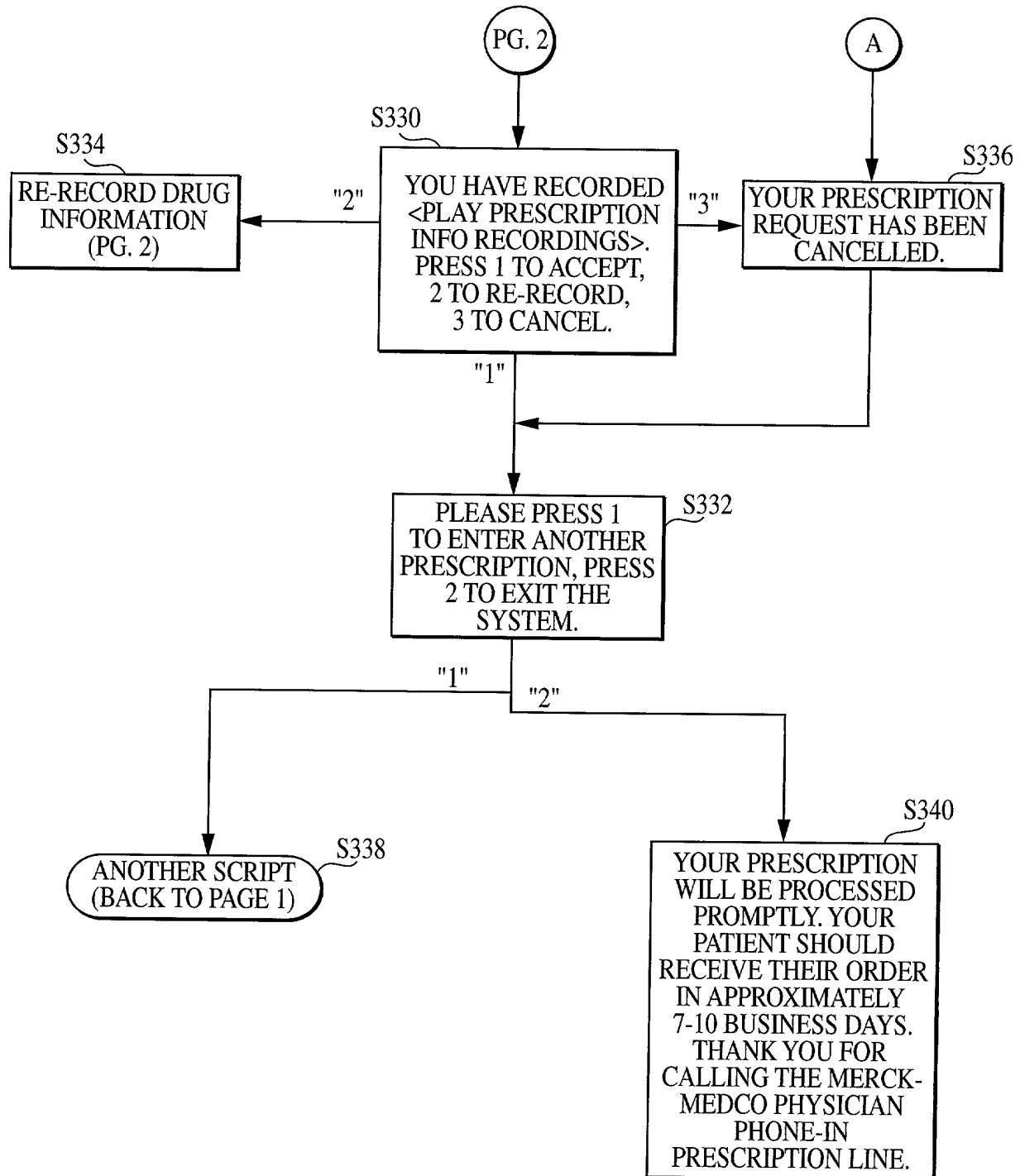


FIG. 7C

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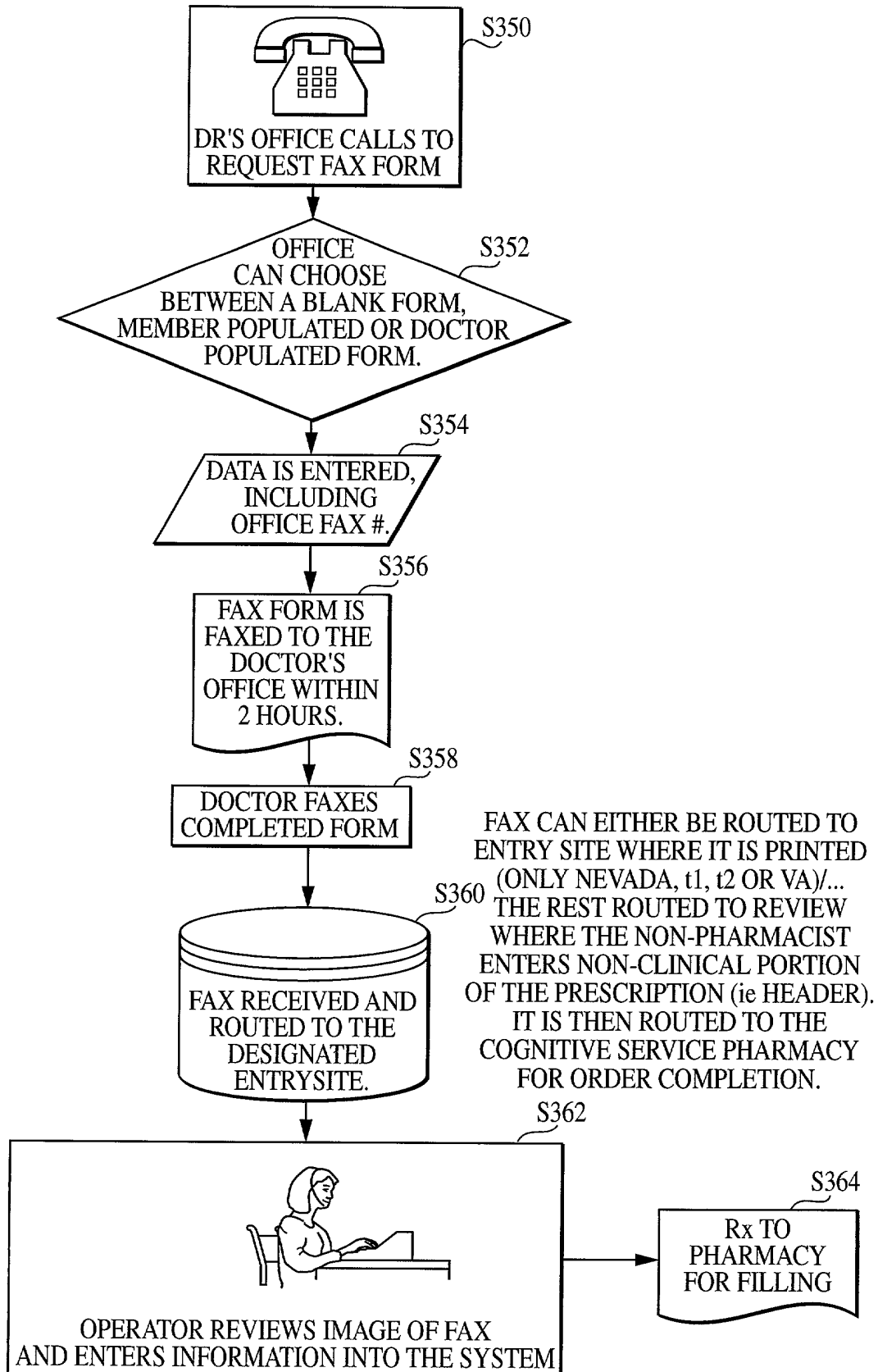


FIG. 8

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Prescription Fax Form

Please fully complete steps 1 to 4 below to help ensure timely processing of your patient's prescription

Questions: Call Customer Service

○ 34191 |  ○

STEP 1 Fill in both the **Subscriber** and the **Patient** information below.

Prescription Drug _____

Card Member #: _____

(Usually different than the health plan ID #)

Subscriber Information (card holder):

Name:(First) _____ (Last) _____

Address: _____

City _____ State _____ Zip Code _____ Phone _____

Patient Name:(First) _____ (Last) _____ DOB: _____

STEP 2:

Confirm your office's secure fax #.
Check the box to indicate a change,
and write in the correct #.

☐ New fax #: _____

STEP 3:

Complete for new patients or for
patients with changes in health.

Please check all that apply:

Allergies:

- | | | |
|----------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine |

Medical Conditions:

- | | | |
|--------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Asthma | <input type="checkbox"/> High B.P. |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Glaucoma | |

Other _____

STEP 4 Please tape the prescription from your prescription
pad here (Most patients can receive up to a 90-day
supply and 4 refills.)

TAPE PRESCRIPTION HERE

Please confirm you have included:

On the form:

- Subscriber's Drug Card Number

On the prescription:

- Patient's Full Name
- Patient's Date of Birth
- Date Prescription Written
- Your Signature

FIG. 9

AUTOFAX FLOW RENEWAL

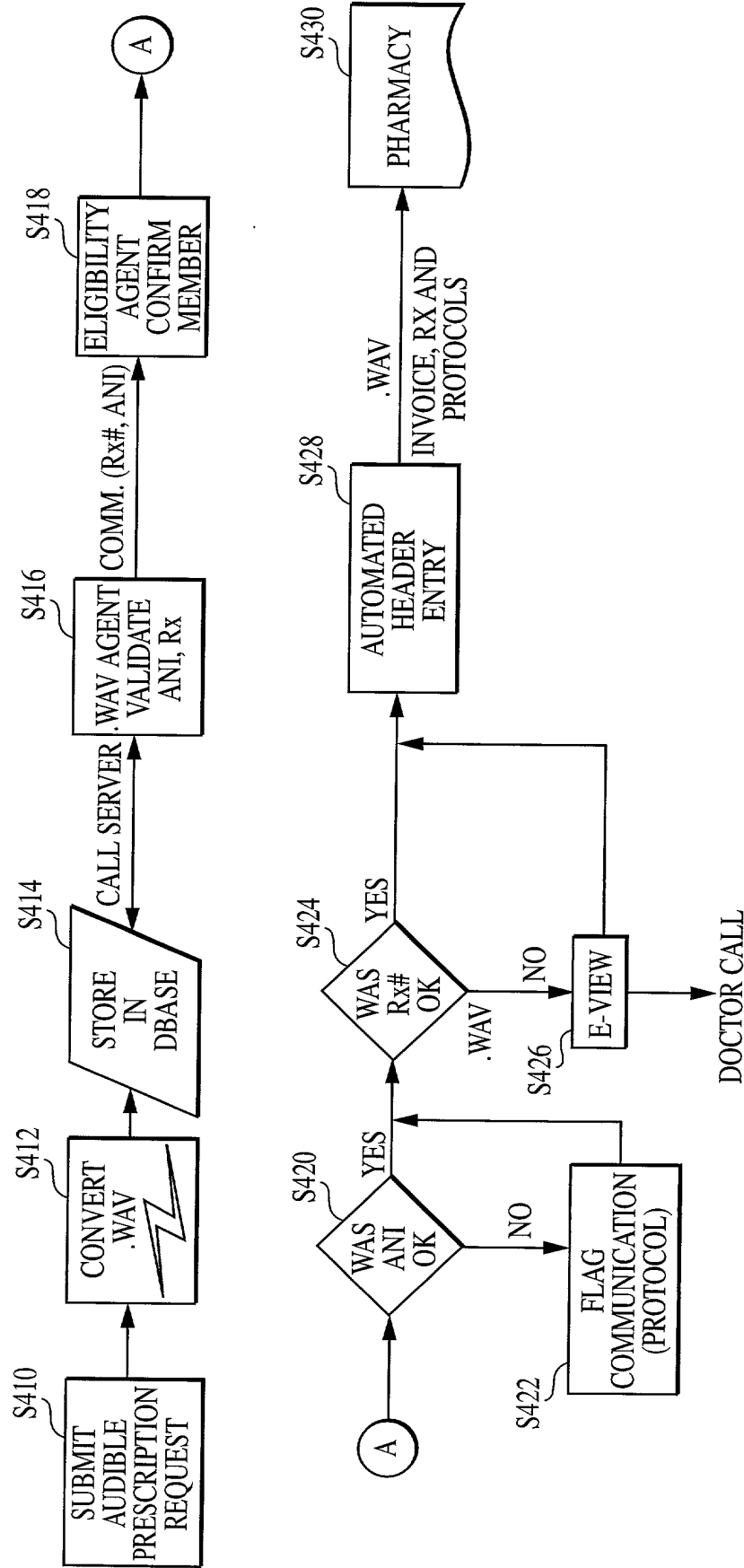


FIG. 10A

AUTOFAX FLOW NEW Rx

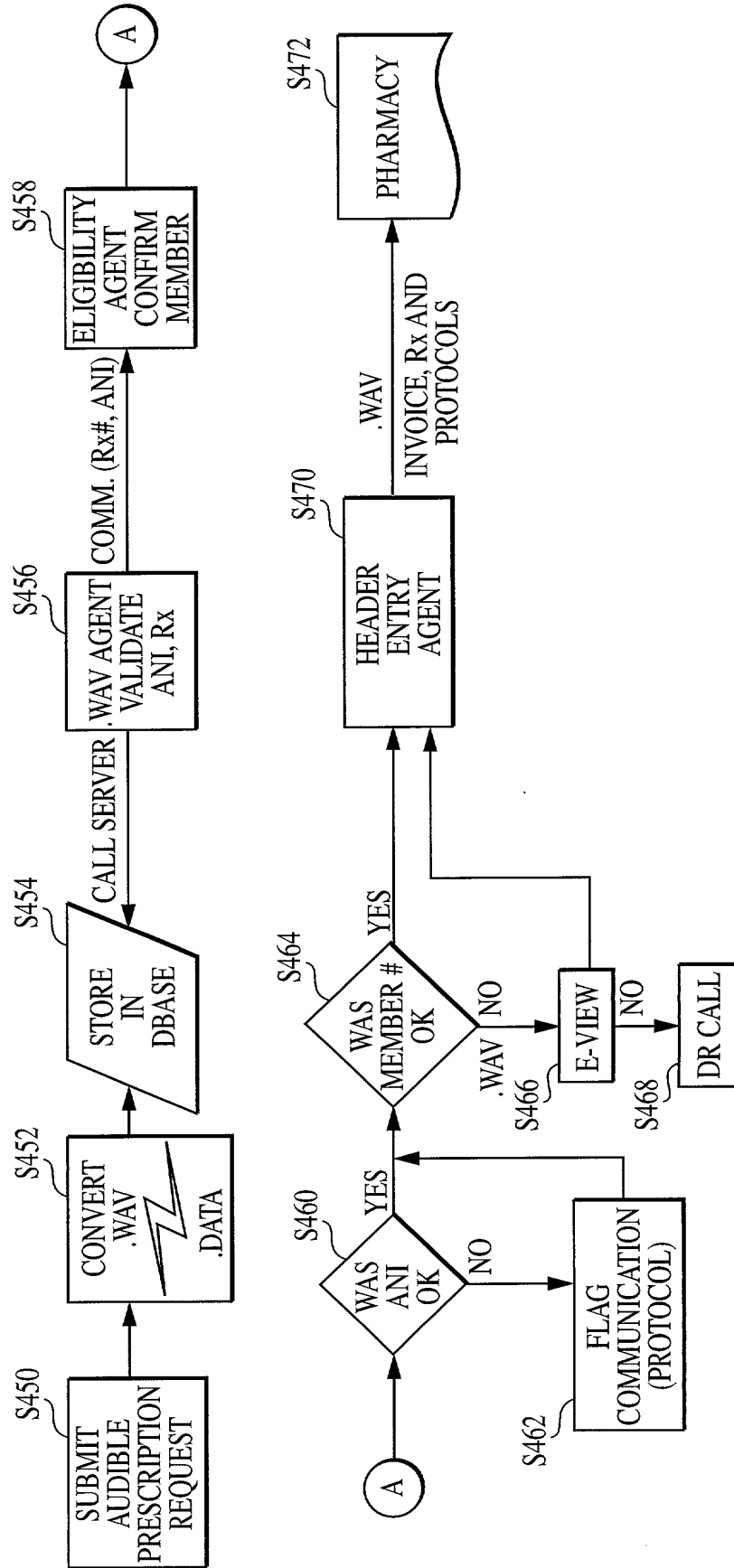


FIG. 10B

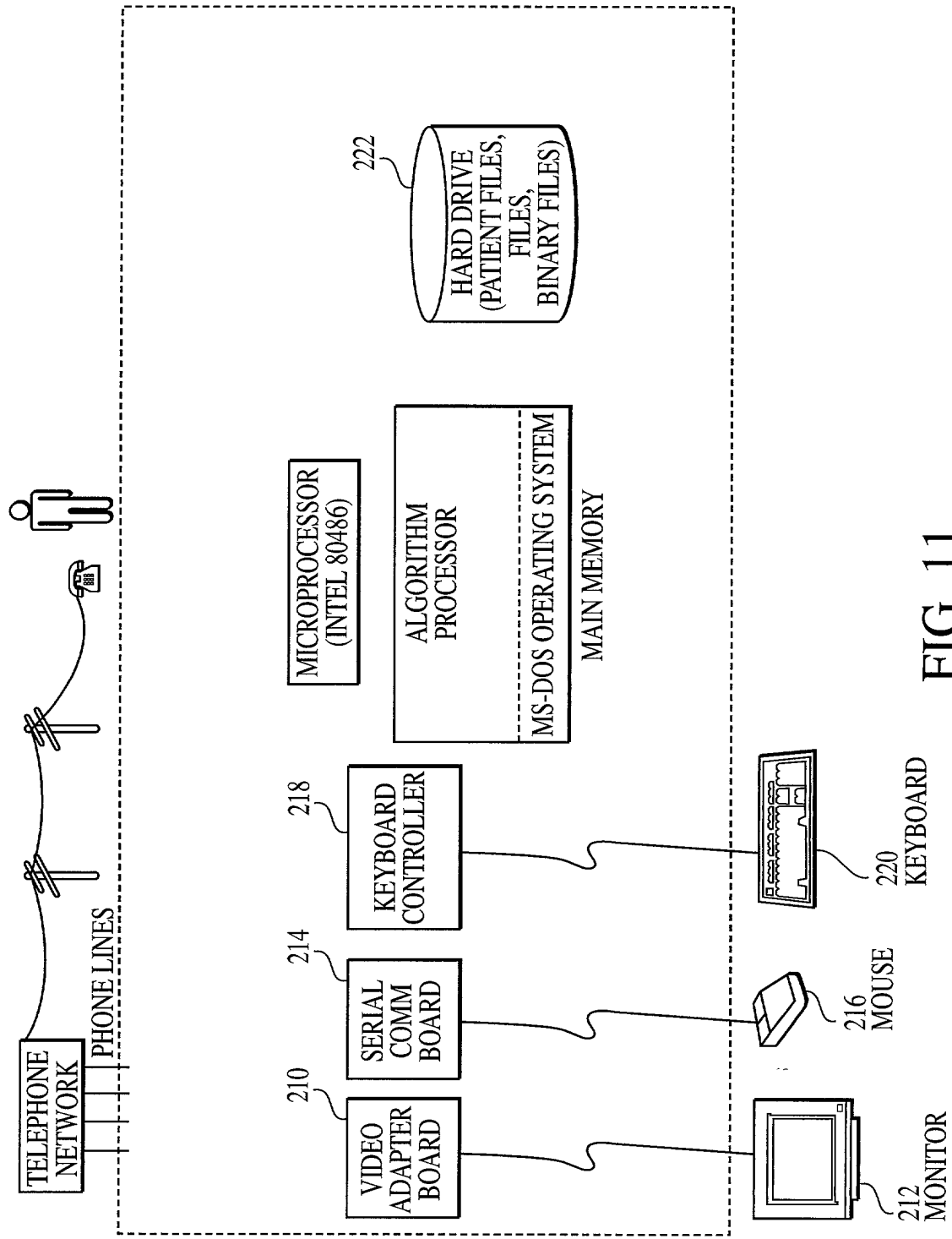
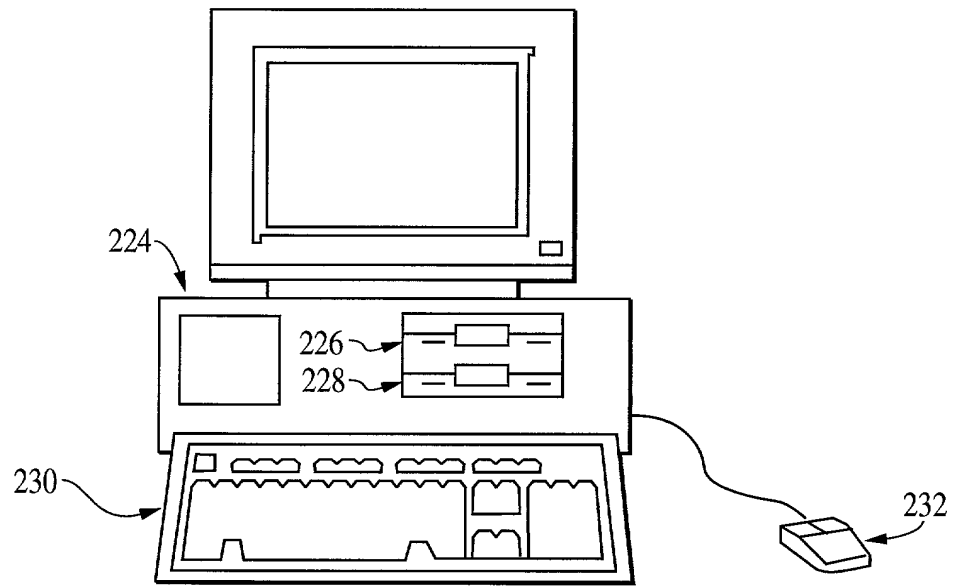


FIG. 11
COMPUTER



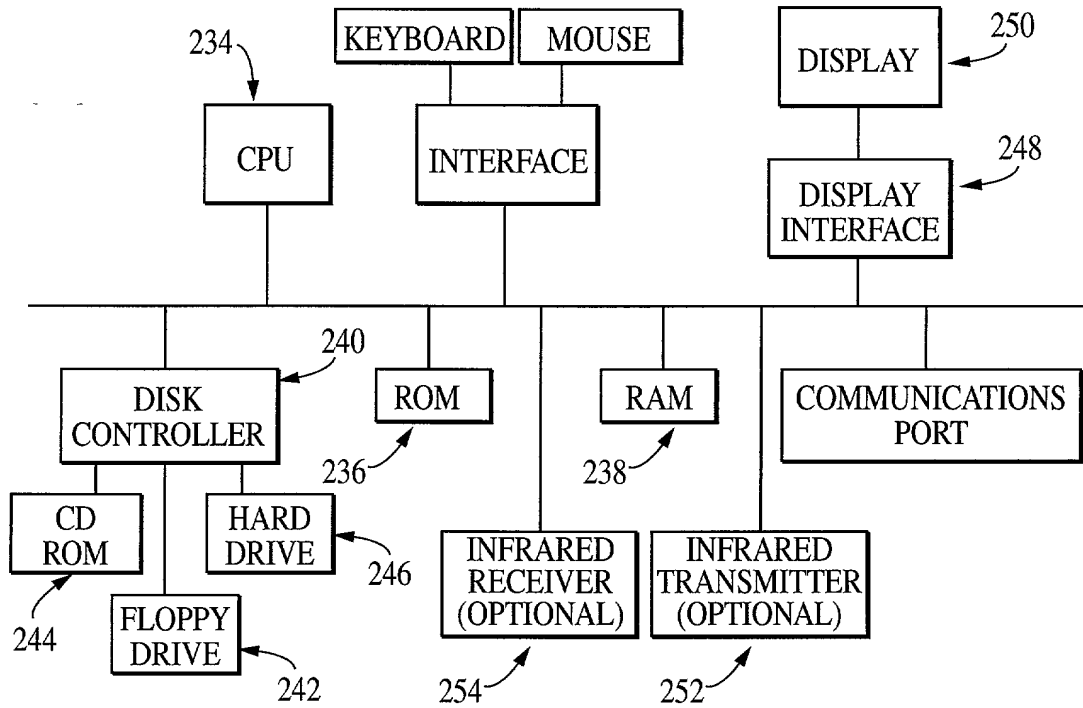


FIG. 13
FLOW OF POTENTIAL
COMPUTER PROCESS

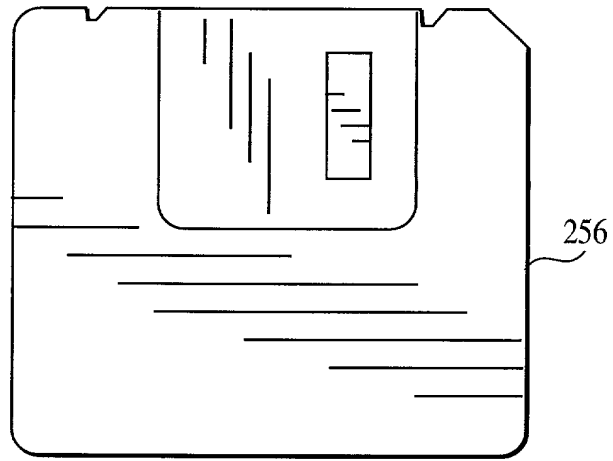


FIG. 14
CONCEPTUAL VIEW OF
MEMORY STORAGE MEDIUM